United Nations ST/IC/2002/77

Secretariat

25 November 2002

Information circular*

To: Members of the staff at Offices away from Headquarters

From: The Controller

Subject: **Van Breda medical, hospital and dental insurance**

I. Renewal provisions for 2003

1. The purpose of the present information circular is to set out the provisions concerning the renewal of the Van Breda hospital, medical, and dental insurance plan for staff members at Offices away from Headquarters New York, which will take effect on 1 January 2003.

2. The Van Breda plan is a global scheme covering staff members and former staff members who reside in all parts of the world, **except** the United States of America (see also para. 11). Staff members, former staff members and their dependants **who reside in the United States of America are not eligible for coverage** under the Van Breda plan. The sole exception to this exclusion arises in the case of a dependent child attending school or university in the United States, who is required to have the health insurance coverage mandated by the educational institution. In this case, the student's health insurance plan will be primary and the Van Breda coverage will be secondary.

3. Pending the issuance of an administrative instruction setting out the eligibility criteria and enrolment rules and procedures governing United Nations contributory health insurance, the existing conditions governing eligibility and enrolment for the Van Breda plan are summarized in paragraphs 10 to 28 of the present circular.

Annual enrolment campaign

4. Staff members are reminded that the annual enrolment campaign will be the only opportunity in 2003 to enrol themselves and eligible family members in the Van Breda plan. The annual enrolment campaign for the Van Breda plan at duty stations around the world is scheduled to be held from 2 to 13 June 2003.

* Expiration date of the present information circular: 31 December 2003.

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Premium levels and benefits

5. The annual cost of the Van Breda plan reflects claims incurred for hospitalization, medical and dental treatment in all parts of the world and reflects widely varying price levels. If levels of plan utilization and the charges levied by hospitals and other medical providers were comparable throughout the world, then loss ratios, that is, the ratio of claim reimbursement to premium paid, would be more or less equal among all locations at which there were significant numbers of participants.

6. The financial performance of the plan for the past policy period was favourable. As a result, premium rates for 2003 will remain unchanged for participants in all locations with the exception of staff and retirees residing in Mexico. Owing to the excess of claims reimbursed over premium collected (loss ratio) over the past few policy periods, it has been decided to apply to participants residing in Mexico the premium levels and percentages of salary applicable to ECLAC Santiago, Chile.

7. In line with the methodology used in the calculation of staff contributions towards premiums for other United Nations insurance schemes, the premium contributions of participants in the Van Breda scheme are determined as a percentage of their respective medical net salaries[1] by applying the rates set out in paragraph 8 below. The percentage contribution rates have been computed to take into account the requirement for an overall 50:50 cost-sharing relationship between the Organization and participants in the plan.

8. The schedule of premiums that will become effective on 1 January 2003, as well as the related staff contribution rates, are set out in the table below.

	Monthly premium (United States dollars)			*Percentage of medical net salary*		
	Effective 1 January			*Effective 1 January*		
Type of coverage	*2001*	*2002*	*2003*	*2001*	*2002*	*2003*
A. All duty stations (other than Chile and Mexico)						
Staff member only	89.00	89.00	89.00	1.31	1.31	1.31
Staff member and one family member	190.00	190.00	190.00	2.05	2.05	2.05
Staff member and two or more eligible family members	314.00	314.00	314.00	3.28	3.28	3.28
B. Chile and Mexico						
Staff member only	160.00	160.00	160.00	2.32	2.32	2.32
Staff member and one family member	337.00	337.00	337.00	3.78	3.78	3.78
Staff member and two or more eligible family members	557.00	557.00	557.00	5.99	5.99	5.99

[1] Medical net salary consists of gross salary, less staff assessment, plus language allowance, non-resident's allowance and post adjustment, as applicable. In no case will staff contributions be greater than 85 per cent of the premiums shown above.

Hospital room rate maxima

9. The daily room rate maxima for hospital accommodation reimbursable under the plan will continue, as follows:

(a) **Europe and North America.** The maximum reimbursement per day for hospital accommodation (room and board) in Europe and North America is $600. Details concerning the application of the $600 per day limit for hospitalization in the United States are set out in annex II to the present circular. Semi-private room accommodation is the normal standard in Europe and North America. Only under the following conditions, subject to the provision of documentation satisfactory to the insurer, will private-room care be reimbursed in full, up to the $600 daily limit:

(i) When the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, that is, it has no standard of accommodation other than private rooms and general wards;

(b) **Israel.** The daily room rate cap applicable in Israel is $700. This reimbursement ceiling conforms to the nationally uniform semi-private hospital accommodation rate in that country;

(c) **Rest of world.** A $330 per day reimbursement ceiling is applicable to all locations other than Europe, North America and Israel.

II. Eligibility criteria and enrolment rules

Eligibility for enrolment in the Van Breda plan

10. Except for staff members whose duty station is within the United States and locally recruited staff members at duty stations where the Medical Insurance Plan (MIP) is established, all staff members holding appointments of three months or longer under the 100 series of the Staff Rules or one month or longer under the 200 series of the Staff Rules may enrol themselves and eligible family members in the Van Breda plan. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in the Van Breda plan.

11. **Staff members are ineligible for coverage under the Van Breda plan if they or their covered dependants reside in the United States.** Staff members enrolled in the Van Breda plan while on assignment to field offices or missions must reapply for a United States-based health insurance plan upon return to Headquarters. Coverage in a United States-based health insurance plan following return from mission assignment will become effective from the first day of the month after return to duty at Headquarters.

12. Enrolment in the Van Breda plan at the time of initial appointment must be accomplished within 31 days of the date of entry on duty. For enrolment purposes, applicants will be required to present (a) a Van Breda application form, and (b) proof of eligibility in the form of a personnel action (PA) document provided by

their respective personnel or administrative officers attesting to the current contractual status. The enrolment of eligible family members requires the provision of evidence of the status of such family members. In most instances, the necessary proof of eligibility will be contained in the personnel action form.

Eligible family members for insurance purposes

13. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25 years, provided that he or she is not married and not in full-time employment; disabled children may be eligible for continued coverage after the age of 25 years.

Enrolment at times other than upon entry on duty

14. Staff members appointed under the 100 series of the Staff Rules who have not enrolled themselves and eligible family members within 31 days of the date of their entry on duty have an opportunity once each year to do so. The annual enrolment period generally is set for the first two weeks of June, the specific dates being announced each year sufficiently in advance of the occasion. The effective date of insurance coverage which is applied for during the annual enrolment period is the first day of the following month.

15. Staff members appointed under the 200 series of the Staff Rules (project personnel) are, under staff rule 206.4 (a), required to participate in a medical insurance scheme provided by the United Nations unless exemption from such participation is expressly stated in the letter of appointment. Staff rule 206.4 (b) provides that such personnel, if appointed for a period of one month or more and participating in a medical insurance scheme provided by the United Nations, may enrol their spouses and dependent children in the scheme. Project personnel who have not enrolled their spouses and eligible dependent children in the Van Breda plan at the time of initial appointment have an annual opportunity to do so. In the case of project personnel, the annual enrolment opportunity occurs on the anniversary of their entry on duty, and insurance coverage for added dependants will be effective as of that date.

16. Eligible staff members holding appointments of limited duration under the 300 series of the Staff Rules who have not enro' ed themselves in the Van Breda plan at the time of initial appointment because they maintain their own coverage have an annual opportunity to do so. The annual enrolment opportunity occurs on the anniversary of their entry on duty.

17. At times other than the annual enrolment periods referred to in paragraphs 14 to 16 above, staff members (100 and 200 series) and their eligible family members may be enrolled in the Van Breda plan *only* if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) Upon transfer from one duty station to another;

(b) Upon return from special leave without pay (see para. 23 below);

(c) Upon assignment to a mission under certain conditions (see para. 24 below);

(d) Upon marriage, birth or legal adoption of a child for coverage of the related family member.

18. Staff members who can demonstrate that they were on mission or annual or sick leave during the annual enrolment opportunity period may enrol within 31 days of their return to their duty station.

19. Applications between enrolment opportunity periods based on circumstances other than those listed in paragraph 17 above or not received within 31 days of the event giving rise to eligibility will not be receivable.

Effective commencement and termination dates of health insurance coverage

20. New coverage for a staff member newly enrolled in the Van Breda plan commences on the first day of a qualifying contract. If the first day of a qualifying contract occurs later than the first day of the month, coverage commences on that day or the participant may opt for coverage to commence on the first day of the following month. In no event can coverage commence prior to the first day of the qualifying contract. **Health insurance coverage terminates at the end of the month in which the qualifying contract ends.** Therefore, if a contract terminates before the last day of a month, coverage will remain in place until the end of that month. Illness or treatment which occurs within the period of the contract will be covered by the plan. Illness and treatment beyond the contract period is not covered.

Insurance enrolment resulting from loss of employment of spouse

21. To date, a staff member whose health insurance coverage has been provided by the employer of his or her spouse has been ineligible to apply for United Nations health insurance coverage in the event of the spouse's loss of employment, except on the occasion of the annual enrolment campaign. Loss of coverage under a spouse's health insurance plan by virtue of the spouse's loss of employment is now considered to constitute a qualifying event for the purpose of enrolment in a United Nations plan. Application for enrolment in a United Nations plan under these circumstances must be made within 31 days of the qualifying event. In addition, application for coverage under this provision must be accompanied by an official letter from the spouse's employer, certifying the termination of employment and its effective date.

Staff transferred to another duty station

22. Staff members who transfer to another duty station but who did not have medical insurance prior to the transfer may enrol themselves and eligible family members in the United Nations health insurance plan upon transfer. The enrolment application must be submitted within 31 days of the date of transfer, and the effective date of coverage will be the transfer date at the new duty station. This provision applies also in the case of transfer to Headquarters, in which case the new enrolment will be in one of the health insurance plans offered at Headquarters. Staff members are reminded that if they transfer from one duty station to another and in the process are transferred from one payroll system to another, they should, upon arrival at the new duty station, ensure that their insurance coverage is recorded in the new payroll system so that the deduction of monthly premium contributions may be continued without a break.

Staff on special leave without pay

23. Staff members who are granted special leave without pay are reminded that they may retain health insurance coverage during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) **Insurance coverage maintained during special leave without pay.** If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Service (if payrolled at Headquarters) or the relevant administrative office (if payrolled elsewhere) *must* be informed directly in writing by the staff member of his or her intention at least one month in advance of the commencement of the special leave. At that time, the administrative office concerned will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage retained (both the staff member's contribution and the Organization's share, since no subsidy is payable during such leave);

(b) **Insurance dropped while on special leave without pay.** Should a staff member decide not to retain insurance coverage while on special leave without pay, no action is required upon commencement of the special leave;

(c) **Re-enrolment upon return to duty following special leave without pay.** Regardless of whether a staff member has decided to retain or drop insurance coverage during a period of special leave without pay, it is essential that he or she re-enrol in the plan within 31 days of return to duty. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan until the following annual enrolment opportunity period.

Staff members on mission assignment

24. With regard to staff members going on mission assignment, it has been decided to continue to extend a special health insurance enrolment opportunity to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are *not* enrolled in the Van Breda plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in the plan in these circumstances must be completed *prior* to the departure of the staff member on mission assignment;

(b) Staff members who elect to enrol in the Van Breda plan in the circumstances set out in subparagraph (a) above forgo the right to make any further change during the annual enrolment period taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment period of the following year;

(c) Staff members going on mission assignment who wish to enrol in the Van Breda plan or change their present coverage, as provided above, must present evidence to the Insurance Service or to their administrative office, as the case may be, of the mission assignment and its duration.

Staff member married to another staff member

25. Staff members are reminded that in the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member. It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service.

Staff members with dependants residing in the United States

26. Staff members are reminded that the Van Breda plan is designed to provide hospital, medical and dental coverage for participants residing outside the United States. Therefore, staff members residing outside the United States but with covered eligible dependants residing in the United States, other than school or university students with health insurance coverage mandated by the educational institution, should enrol instead in a Headquarters health insurance plan. It should be noted that at Headquarters, dental coverage is a separate plan component for which specific application must be made.

Cessation of coverage of family members

27. The Insurance Service at Headquarters or the relevant administrative office should be notified immediately in writing of changes in the staff member's family which result in a family member ceasing to be eligible (for example, a spouse upon divorce, a child reaching the age of 25 years, marrying or taking up full-time employment). Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. The responsibility for initiating the resulting change in coverage (for example, from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") rests with the staff member. It is in the interest of staff members to provide this notification promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution that may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Service or administrative office.

After-service health insurance

28. Established policy in regard to eligibility to participate in the United Nations after-service health insurance programme, as well as the related administrative procedures, is set out in administrative instruction ST/AI/394, dated 19 May 1994. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, they must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over at the date of separation. It should also be noted that only family members enrolled with the staff member at the time of separation are eligible

for continued coverage under the after-service health insurance programme. **Former staff members who reside in the United States are reminded that they are ineligible for participation in the Van Breda plan and that they must switch to a Headquarters plan within 31 days of taking up residence in the United States.**

Retirees who return to active service

29. Retirees who return to active service with the Organization may temporarily be ineligible for health insurance coverage under the United Nations after-service health insurance programme. Eligibility for enrolment in the after-service health insurance programme is contingent upon eligibility to receive a monthly benefit from the United Nations Joint Staff Pension Fund. If as a result of a new post-retirement appointment the former staff member again becomes an active staff member, the monthly pension benefit is suspended and, for the duration of the suspension of pension benefits, eligibility to participate in the after-service health insurance programme is also suspended. In such cases, it is the obligation of the individual concerned to promptly notify the Insurance Service of the new active appointment and to make the necessary arrangements for a switch in health insurance enrolment from after-service health insurance status to that of an active staff member. When the active appointment ends, the Insurance Service must again be informed promptly so that the after-service health insurance status can be reactivated.

III. Conversion privileges

30. Participants (subscribers) who cease employment with the United Nations and do not qualify for after-service health insurance benefits may arrange for medical coverage with Van Breda under the terms of an "individual health insurance plan", provided that application is made within 31 days of termination of coverage under the United Nations group policy. Covered eligible dependants may also participate in the Van Breda individual insurance plan along with the subscriber. However, children over the age of 25 are not eligible for health insurance conversion under the Van Breda plan. In the case of a spouse of a staff member whose eligibility for coverage ceases as a result of divorce, application for medical coverage under the above arrangement must be made within 31 days of termination of coverage under the United Nations group medical coverage. The conversion privilege, which is part of the United Nations group contract with Van Breda, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. However, this privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of an individual health insurance plan. **The conversion privilege is designed to provide coverage during a period of transition to more permanent health insurance coverage. Therefore, effective 1 January 2003, the conversion privilege will grant coverage up to a maximum of 24 months.** Details concerning conversion to an individual insurance policy may be obtained by communicating directly with Van Breda at the following address:

J. Van Breda and Co. International
Plantin en Moretuslei 295
B-2140 Borgerhout
Antwerp, Belgium
Fax No.: 00 323 272 39 69
Telephone No.: 00 323 217 5743

IV. Claims and enquiries

Basis for claim reimbursement in United States dollars

31. Claim reimbursement is made in United States dollars, converted from the currency in which the hospital, medical or dental expenses have been incurred. Reimbursement in United States dollars is based on the United Nations operational rate of exchange in effect on the date that the medical and dental expenses are incurred and, in the case of hospital expenses, on the date that the hospital bill is rendered.

Mailing addresses

32. Participants must inform their administrative office of any change in their mailing address in order to ensure that identification cards, reimbursements and explanations of benefits are delivered promptly and appropriately.

Where to address claims and benefit enquiries

33. Although the staff of the Insurance Service is available to assist staff members in administrative matters concerning participation in the Van Breda plan, claims questions should always be taken up on the first instance directly with the insurance company concerned. The address and telephone and fax numbers of Van Breda are provided in paragraph 30 above.

34. Annex I to the present circular contains a summary of the benefits payable under the Van Breda plan.

35. Annex II contains a recapitulation of the provisions pertaining to hospitalization in the United States.

36. Annex III sets out relevant details concerning 16 surgical procedures for which a second opinion will be reimbursed in full.

Annex I

Van Breda insurance scheme

1. The Van Breda insurance scheme provides for reimbursement of medical, hospital and dental treatment costs up to a maximum of $250,000 per insured participant per calendar year. In addition to the maximum reimbursement per calendar year, certain maxima per treatment, procedure or service may also be applied on the basis of a determination of "reasonable and customary" charges for the benefit at the place of treatment. Fees for treatments, procedures or services which may be considered by Van Breda to be excessive compared with prevailing fee levels will be reimbursed up to the reasonable and customary level for the geographical area in which such medical services are received.

2. The scheme is subject to the following reimbursement provisions and limitations:

(a) Under the basic coverage component, reimbursement in respect of medical treatment prescribed by qualified doctors is limited to 80 per cent of the costs incurred, including doctors' fees;

(b) Under the major medical coverage component, 80 per cent of the remaining unpaid costs is paid, subject to an annual deductible (co-payment) of $200 per participant and $600 per family;

(c) The following example illustrates how reimbursement in respect of basic coverage and major medical coverage operates:

	United States dollars
(i) Basic coverage	
Cost of medical treatment (if reasonable and customary)	3 200
Reimbursement under basic coverage (80 per cent)	-2 560
Residual (20 per cent)	640
(ii) Major medical coverage	
Basis for major medical coverage (20 per cent residual remaining under basic coverage)	640
Annual (calendar year) deductible	-200
Basis for major medical coverage after application of deductible	440
Reimbursement under major medical coverage: 80 per cent of expenses in excess of deductible ($440 x 80 per cent)	352
(iii) Total reimbursement (recapitulation of (i) and (ii))	
Basic coverage	2 560
Major medical coverage	+352
Total reimbursement	2 912
Participant's total out-of-pocket expense	288

(d) The cost of hospital services (excluding doctors' fees) is reimbursed at the rate of 100 per cent of the costs involved, including such items as bed and board,

general nursing service, use of the operating room and equipment, use of the recovery room and equipment, laboratory examinations, X-ray examinations and drugs and medicines for use in the hospital. For hospitalization in Europe and in North America, the standard of accommodation is limited to semi-private room care, that is, two or more patients in the same room, except that, under the following circumstances, subject to the provision of documentation satisfactory to the insurer, private-room care will be reimbursed in full up to the daily limit specified in subparagraph 2 (e) (i) below:

(i) When the nature and gravity of the illness requires private-room care and the need for such care is substantiated by the attending physician;

(ii) When the patient is admitted on an emergency basis to a hospital that has semi-private accommodation but none is available at the time;

(iii) When the patient is admitted to a hospital that does not have any semi-private accommodation, that is, it has no standard of accommodation other than private rooms and general wards;

Europe and North America are defined for this purpose as Europe, including Malta, Cyprus and Turkey (European portion), and Canada and the United States of America;

(e) Reimbursement for hospital accommodation expenses is subject to daily room rate caps. These caps will be maintained in 2003, as follows:

(i) *Europe and North America.* The maximum reimbursement per day for hospital accommodation (room and board) in Europe and North America is $600;

(ii) *Israel.* The daily room rate cap applicable in Israel is $700;

(iii) *Rest of world.* A $330 per day reimbursement ceiling is applicable to all locations other than Europe, North America and Israel;

(f) Well-child care/immunizations are covered at 80 per cent of the reasonable and customary fee levels under the basic component of the plan, and a further 80 per cent under the major medical component, if applicable, in accordance with the following schedule:

Well-child care to the age of 7 years:

6 visits per year aged 0 to 1 year

2 visits per year aged 1 to 2 years

1 visit per year aged 2 to 7 years

1 visit every 24 months from age 7 to 19 years;

(g) The cost of dental treatment is reimbursable at the rate of 80 per cent up to a maximum sum of $900 per insured participant per calendar year. The cost of dento-facial orthopaedics is covered only if the treatment is started before the patient has reached his or her fifteenth birthday, and reimbursement is provided only during a treatment period of four years;

(h) The cost of outpatient mental health treatment by a psychiatrist is covered, as are the services of a licensed psychoanalyst, a licensed psychologist or a

licensed psychiatric social worker. The cost in respect of insured participants is reimbursable at the rate of 80 per cent of the reasonable and customary fee level and to a maximum reimbursement of $1,000 per insured person in any 12-month period;

(i) The cost of treatment for substance (alcohol and/or drug) abuse is covered, under certain conditions. The coverage includes inpatient treatment for detoxification and rehabilitation at a facility certified for such treatment, subject to the prior approval of Van Breda. Such treatment will normally be limited to 30 days in a calendar year. In addition, the plan covers outpatient counselling for the purpose of diagnosis and treatment. The costs of outpatient counselling are reimbursable at the rate of 50 per cent and to a maximum reimbursement of $1,000 for not more than 50 visits per insured person in any consecutive 12-month period. Of these 50 visits, up to 20 may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem;

(j) The cost of radiological treatment is reimbursable at the rate of 80 per cent of the reasonable and customary fee level under the basic component and a further 80 per cent under the major medical component, provided that the patient has been referred to the specialist by the doctor in attendance;

(k) A routine eye examination is covered every 24 months at 80 per cent of the reasonable and customary fee level of the plan, and a further 80 per cent under the major medical component, if applicable;

(l) The cost of hearing aids and optical lenses is covered, with the following limitations:

(i) *Hearing aids*. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $300 per apparatus, including the related examination, and a maximum of one apparatus per ear in any period of three years;

(ii) *Optical lenses*. Reimbursement at 80 per cent (only basic coverage, no major medical coverage), with a maximum of $60 per lens and a maximum of two lenses in any period of two years. These maxima will also apply to surgical or laser treatment for the correction of refraction;

In order to be entitled to these benefits, a staff member or the participating family member will have to have been a participant in the Van Breda scheme for one year or more;

(m) The cost of two blood tests per year for the human immunodeficiency virus;

(n) A mammography screening (examination) comprising the following provisions:

(i) Upon recommendation of a physician, a mammogram may be covered at any age for persons having a prior history of breast cancer or whose mother or sister has had a prior history of breast cancer;

(ii) A single baseline mammogram will be covered for persons aged from 35 through 39 years;

(iii) A mammogram will be covered every two years, or more frequently upon the recommendation of a physician, for persons aged from 40 through 49 years, inclusive;

(iv) An annual mammogram will be covered for persons aged 50 and older;

Mammography screenings are covered whether carried out in a medical provider's office, hospital outpatient department, hospital ambulatory surgery department or ambulatory surgery facility, or another facility that is licensed to provide mammography screenings. The screening is covered in accordance with the reimbursement provisions and limitations set out above;

(o) Urological examinations and Prostate Specific Antigen (PSA) screenings are covered as follows:

(i) In asymptomatic males over the age of 40 years, one urological exam and PSA screening is covered every two years. An annual exam and screening is covered after the age of 75 years;

(ii) For all other males, including men with a family history of prostate cancer, aged 40 years and over, one urological exam and PSA screening per year is covered;

Urological examinations and PSA screenings are covered in accordance with the reimbursement provisions and limitations set out above.

3. The insurance scheme does not cover:

(a) Periodic preventive health examinations;

(b) Injuries as a consequence of voluntary or intentional action on the part of the insured participant;

(c) Insured participants who are mobilized or who volunteer for military service in time of war;

(d) Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);

(e) The consequences of insurrections or riots if, by taking part, the insured participant has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;

(f) Spa cures, rejuvenation cures or cosmetic treatment (cosmetic surgery is covered where it is necessary as the result of an accident for which coverage is provided);

(g) The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;

(h) Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded;

(i) In-vitro fertilization.

4. In respect of the 16 surgical procedures listed in annex III to the present circular, the cost of a second opinion will be reimbursed at 100 per cent and, should a participant desire a third opinion, the cost of that opinion will also be reimbursed at the rate of 100 per cent. No penalty will be assessed in cases in which surgery is performed without the benefit of a second opinion.

5. Subscribers should note that claims for reimbursement must be submitted to Van Breda no later than two years from the date on which the medical expenses were incurred. *Claims received by Van Breda later than two years after the date on which the expense was incurred will not be eligible for reimbursement.*

Annex II

Provisions pertaining to hospitalization in the United States of America

1. While a participant is free to seek admission to a hospital in the United States of America without providing any notification to Van Breda, reimbursement for such hospitalization will be subject to a limit of $600 in respect of the daily semi-private room rate. Thus, if a participant chooses a hospital at which the daily semi-private room rate exceeds $600, the cost of the daily room rate above $600 will be borne entirely by the participant. There will be no change in the reimbursement for other services. In this connection, it should be noted that hospital costs vary considerably throughout the United States, and costs may exceed the $600 reimbursement ceiling, particularly in parts of California, Florida, Massachusetts, New York, Texas and Washington, D.C., where the costs may be much higher in certain hospitals.

2. The *$600 limit will not apply* to semi-private hospital accommodation in three specific circumstances:

(a) In connection with medical evacuation to any hospital in the United States authorized by the United Nations Medical Director;

(b) In cases of **bona fide** medical emergency arising while in the United States;

(c) In situations where the necessary medical treatment can only be provided at a hospital where the daily semi-private room rate exceeds $600 and to avoid the obligation to meet daily room-rate expenses in excess of $600. In such cases, confirmation must be obtained from Van Breda prior to hospital admission.

3. Please note that staff members, former staff members and their eligible dependants who **RESIDE** in the United States are not eligible for coverage under the Van Breda plan.

Annex III

Second surgical opinion requirement

1. There is no reimbursement penalty for failure to provide evidence of a second opinion in connection with any surgery. Whenever feasible, however, participants are encouraged to seek a second surgical opinion, in particular for the 16 surgical procedures listed below. For this reason, Van Breda will reimburse at 100 per cent the cost of a second opinion rendered by a qualified physician in connection with these 16 surgical procedures. If the second opinion does not agree with the first, a third opinion may be sought and will also be fully reimbursed. Please note that the second (or third) opinion must be provided by a physician not associated or in practice with the physician who originally recommended or proposed to perform the surgery.

2. The 16 surgical procedures for which second opinions will be reimbursed at the rate of 100 per cent are:

	Procedure	*Explanation*
1	Bunionectomy	Removal of bunions
2	Cholecystectomy	Removal of gall bladder
3	Dilation and curettage	Dilation of cervix and scraping of uterus
4	Excision of cataracts	Removal of cataracts
5	Haemorrhoidectomy	Removal of haemorrhoids
6	Hernia (inguinal) repair	Repair of hernia in the groin
7	Hysterectomy	Removal of uterus
8	Knee surgery	Knee operation
9	Laminectomy	Removal of part of spine
10	Mastectomy: partial or complete	Partial or complete removal of breast tissue
11	Prostatectomy	Removal of prostate
12	Septo-rhinoplasty	Nose surgery for functional improvement
13	Spinal fusion	Surgical welding of spine segments
14	Tonsillectomy and/or adenoidectomy	Removal of tonsils and/or adenoids
15	Varicose veins	Removal and tying of varicose veins
16	Coronary artery bypass	Heart surgery to bypass one or more blocked arteries feeding the heart